

		FOR OFF USE				

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0046086</u></p> <p>Facility Name: <u>Havana Health Care Center</u></p> <p>Address: <u>609 North Harpham Street</u> <u>Havana</u> <u>62644</u> Number City Zip Code</p> <p>County: <u>Mason</u></p> <p>Telephone Number: <u>(309) 543-6121</u> Fax # <u>(309) 543-1233</u></p> <p>IDPA ID Number: <u>371346306008</u></p> <p>Date of Initial License for Current Owners: <u>03/01/01</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page </p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 30%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p style="text-align: center;"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input checked="" type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____																												
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>																												

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Havana Health Care Center# 0046086 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>78</u>	Intermediate (ICF)	<u>78</u>	<u>28,470</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,357</u>		<u>2,080</u>	<u>4,437</u>	8
9	SNF/PED					9
10	ICF	<u>17,509</u>	<u>5,689</u>		<u>23,198</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,866</u>	<u>5,689</u>	<u>2,080</u>	<u>27,635</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.26%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 03/01/01

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 03/01/01NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 20 and days of care provided 2,080Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	136,262	19,195		155,457		155,457	3,324	158,781		1
2	Food Purchase		162,776		162,776		162,776	105	162,881		2
3	Housekeeping	83,406	11,020		94,426		94,426	75	94,501		3
4	Laundry	40,332	8,048		48,380		48,380	6	48,386		4
5	Heat and Other Utilities			84,758	84,758		84,758	506	85,264		5
6	Maintenance	40,361	36,069	7,436	83,866		83,866	4,360	88,226		6
7	Other (specify):* Home Ofc. Benefits							949	949		7
8	TOTAL General Services	300,361	237,108	92,194	629,663		629,663	9,325	638,988		8
	B. Health Care and Programs										
9	Medical Director			14,600	14,600		14,600		14,600		9
10	Nursing and Medical Records	965,308	87,157	200	1,052,665		1,052,665	5,497	1,058,162		10
10a	Therapy	75,134			75,134		75,134	4	75,138		10a
11	Activities	40,901	705	5,312	46,918		46,918		46,918		11
12	Social Services	22,512			22,512		22,512		22,512		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefits							762	762		15
16	TOTAL Health Care and Programs	1,103,855	87,862	20,112	1,211,829		1,211,829	6,263	1,218,092		16
	C. General Administration										
17	Administrative	61,538			61,538		61,538	23,543	85,081		17
18	Directors Fees										18
19	Professional Services			9,989	9,989		9,989	6,835	16,824		19
20	Dues, Fees, Subscriptions & Promotion			4,367	4,367		4,367	2,035	6,402		20
21	Clerical & General Office Expense	27,907	6,296	11,528	45,731		45,731	30,377	76,108		21
22	Employee Benefits & Payroll Taxes			245,718	245,718		245,718		245,718		22
23	Inservice Training & Education			7,624	7,624		7,624	494	8,118		23
24	Travel and Seminars							677	677		24
25	Other Admin. Staff Transportation			3,197	3,197		3,197	2,462	5,659		25
26	Insurance-Prop.Liab.Malpractice			41,733	41,733		41,733	899	42,632		26
27	Other (specify):* Home Ofc. Benefits							6,758	6,758		27
28	TOTAL General Administration	89,445	6,296	324,156	419,897		419,897	74,080	493,977		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,493,661	331,266	436,462	2,261,389		2,261,389	89,668	2,351,057		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Havana Health Care Center

#0046086

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			92,773	92,773		92,773	22,514	115,287			30
31	Amortization of Pre-Op. & Org											31
32	Interest			188,001	188,001		188,001	5,804	193,805			32
33	Real Estate Taxes			67,200	67,200		67,200		67,200			33
34	Rent-Facility & Grounds							546	546			34
35	Rent-Equipment & Vehicle			6,353	6,353		6,353	134	6,487			35
36	Other (specify): ^a											36
37	TOTAL Ownership			354,327	354,327		354,327	28,998	383,325			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		46,952		46,952		46,952		46,952			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify): ^a Nonallowable Cost			46,073	46,073		46,073	(46,073)				43
44	TOTAL Special Cost Centers		46,952	99,728	146,680		146,680	(46,073)	100,607			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,493,661	378,218	890,517	2,762,396		2,762,396	72,593	2,834,989			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(2,530)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,187	30		9
10	Interest and Other Investment Income	(18)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,381)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	638	43		24
25	Fund Raising, Advertising and Promotiona	(5,853)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employee				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule See PG 5A	(37,824)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,981)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	101,574		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 101,574		36
37	(sum of SUBTOTALS (A) and (B))	\$ 72,593		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center

Provider #: 0046086

1/1/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Reference
Misc. - Part A	(768)	43
Labs - Part A	(26,341)	43
X-Rays - Part A	(9,638)	43
Nonallowable Rotary & Chamber of Comm. dues	(1,077)	20
Total	<u>(37,824)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center

ID# 0046086

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. - Part A	\$ (768)	43	1
2	Labs - Part A	(26,341)	43	2
3	X-Rays - Part A	(9,638)	43	3
4	Nonallowable Rotary & Chamber of Comm. dues	(1,077)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,824)		49

Summary A

12/31/2005

[illegible]

Summary B

12/31/2005

[illegible]

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,324	\$ 3,324	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	105	105	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	75	75	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	6	6	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	506	506	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	4,360	4,360	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	949	949	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,497	5,497	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	4	4	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	762	762	10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	23,543	23,543	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,835	6,835	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	3,112	3,112	13
14	Total			\$			\$ 49,078	\$ *	49,078 14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Havana Health Care Center**# **0046086**Report Period Beginning: **01/01/2005** Ending: **12/31/2005****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 30,377	\$ 30,377 15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	494	494 16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	677	677 17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,462	2,462 18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	899	899 19
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,758	6,758 20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,327	4,327 21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,822	5,822 22
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	546	546 23
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	134	134 24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ 52,496 \$ *	52,496 39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health care
0046086
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watsika Rehabilitation & Health Care Center	Watsika, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
R/LP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2.5	4.00	Salary	\$ 23,543	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,543		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 8

Facility Name & ID Number Havana Health Care Center# 0046086 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	683,169	46	\$ 82,166	\$ 81,693	27,635	\$ 3,324	1
2	2	Food	Patient Days	683,169	46	2,606		27,635	105	2
3	3	Housekeeping	Patient Days	683,169	46	1,857		27,635	75	3
4	4	Laundry	Patient Days	683,169	46	144		27,635	6	4
5	5	Utilities	Patient Days	683,169	46	12,513		27,635	506	5
6	6	Maintenance	Patient Days	683,169	46	107,775	81,080	27,635	4,360	6
7	7	Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		27,635	949	7
8	10	Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	27,635	5,497	8
9	10A	Therapy	Patient Days	683,169	46	88		27,635	4	9
10	15	Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		27,635	762	10
11	17	Administrative	Patient Days	683,169	46	582,000	582,000	27,635	23,543	11
12	19	Professional Services	Patient Days	683,169	46	168,984		27,635	6,835	12
13	20	Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		27,635	3,112	13
14	21	Clerical & General Office	Patient Days	683,169	46	750,958	577,218	27,635	30,377	14
15	23	Inservice Training & Education	Patient Days	683,169	46	12,208		27,635	494	15
16	24	Travel & Seminar	Patient Days	683,169	46	16,731		27,635	677	16
17	25	Other Admin. Staff Transport	Patient Days	683,169	46	60,875		27,635	2,462	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		27,635	899	18
19	27	Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		27,635	6,758	19
20	30	Depreciation	Patient Days	683,169	46	106,965		27,635	4,327	20
21	32	Interest	Patient Days	683,169	46	143,934		27,635	5,822	21
22	34	Rent - Facility & Grounds	Patient Days	683,169	46	13,500		27,635	546	22
23	35	Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		27,635	134	23
24										24
25	TOTALS					\$ 2,511,007	\$ 1,452,642		\$ 101,574	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle Bank		X	Mortgage	\$3,179.00	08/31/02	\$ 2,935,484	\$ 2,798,749	08/01/07	0.0750	\$ 177,226	1	
2	Bank of Farmington		X	Van	\$1,126.00	03/28/01	54,060		04/27/05	0.0750	248	2	
3	Bank of Farmington		X	Car	\$585.00	05/30/05	14,030		04/30/06	0.0750	318	3	
4	Bank of Farmington		X	Jeep Cherokee	\$228.00	06/30/04	7,332		08/08/07	0.0750	440	4	
5												5	
	Working Capital												
6	LaSalle Bank		X	Line of Credit	Interest only	8/31/02	254,682		12/31/05	Varies	9,769	6	
7												7	
8												8	
9	TOTAL Facility Related					\$5,118.00		\$ 3,265,588	\$ 2,798,749			\$ 188,001	9
	B. Non-Facility Related*												
10												10	
11								Home office allocation			5,822	11	
12								Interest income offset			(18)	12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$ 5,804	14
15	TOTALS (line 9+line14)							\$ 3,265,588	\$ 2,798,749			\$ 193,805	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Havana Health Care Center**# **0046086** Report Period Beginning: **01/01/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	67,300	1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	69,249	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	1,949	3										
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	65,251	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	67,200	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2000	63,650	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004 \$ 13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ 14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ 15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION\$ 16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13	14	PLUS APPEAL COST FROM LINE 5 \$ 14	15	LESS REFUND FROM LINE 6 \$ 15	16	AMOUNT TO USE FOR RATE CALCULATION\$ 16
FOR OHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ 14														
15	LESS REFUND FROM LINE 6 \$ 15														
16	AMOUNT TO USE FOR RATE CALCULATION\$ 16														
	2001	65,743	9												
	2002	68,754	10												
	2003	67,250	11												
	2004	69,249	12												
Real estate tax accrual based 100% on prior year tax bill.															

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309-691-8113 FAX #: 309-691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	005-3910000	Facility	\$ 20.00	\$ 20.00
2.	005-1479000	Facility	\$ 69,229.00	\$ 69,229.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 69,249.00	\$ 69,249.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center

0046086 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	418,945	2001	\$ 200,000	1
2					2
3	TOTALS			\$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
98	2001	1971	\$ 1,314,000	\$ 33,692	35	\$ 37,543	\$ 3,851	\$ 168,943	4
	Allocated from Home Office								5
	2005		27,538			516	516	516	6
									7
									8
Improvement Type**									
Roof	2001		22,650	581	20	1,133	552	5,098	9
Flooring	2001		5,890	151	20	295	144	1,327	10
Landscaping	2001		8,984	622	20	449	(173)	2,021	11
A/C Heating Unit	2001		2,046	128	20	102	(26)	583	12
Fencing	2002		758	19	20	38	19	133	13
Roofing	2002		500	13	20	25	12	88	14
Ceiling Tiles	2003		9,516	244	20	476	232	1,190	15
Doors	2004		2,305	59	20	115	56	173	16
Nursing Station	2004		8,100	1,984	20	405	(1,579)	608	17
Furnace	2004		3,382	828	20	169	(659)	254	18
Water Heater	2004		2,281	559	20	114	(445)	171	19
Concrete slab work	2005		3,919	131	20	98	(33)	98	20
									21
									22
2005 Allocation from Home Office Land Improvements		2005	1,592			49	49	49	23
2005 Allocation from Home Office Building Improvements		2005	45			2	2	2	24
									25
									26
									27
									28
									29
									30
									31
									32
									33
									34
									35
									36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,413,506	\$ 39,011		\$ 41,529	\$ 2,518	\$ 181,254	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component/ Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 371,290	\$ 38,132	\$ 53,044	\$ 14,912	7	\$ 208,432	71
72	Current Year Purchases	31,505	4,500	1,575	(2,925)	10	1,575	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			3,760	3,760			74
75	TOTALS	\$ 402,795	\$ 42,632	\$ 58,379	\$ 15,747		\$ 210,007	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	\$ 46,577	\$ 5,366	\$ 9,315	\$ 3,949	5	\$ 41,918	76
77	Facility Use	1999 Oldsmobile	2001	12,992	1,497	2,598	1,101	5	11,692	77
78	Facility Use	2001 Chevrolet	2003	10,002	1,920	2,000	80	5	5,000	78
79	Facility Use	1997 Jeep	2004	7,333	2,347	1,466	(881)	5	2,199	79
80	TOTALS			\$ 76,904	\$ 11,130	\$ 15,379	\$ 4,249		\$ 60,809	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,093,205	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,773	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 115,287	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,514	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 452,070	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5			Home office allocation		546			5
6								6
7	TOTAL				\$ 546			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
 16. Rental Amount for movable equipment: \$ 6,487 Description: Oxygen tanks & nursing equipment-4659; copier-1694; Home Office Alloc. \$134
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning
 Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ <u> </u>
13.	<u>/2007</u>	\$ <u> </u>
14.	<u>/2008</u>	\$ <u> </u>

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10A(1)	3141	hrs	\$	69,103		\$		3,141	\$	69,103		1	
2	Licensed Speech and Language Development Therapist	10A(1)	201	hrs		6,031				201		6,031		2	
3	Licensed Recreational Therapist			hrs										3	
4	Licensed Physical Therapist			hrs										4	
5	Physician Care			visits										5	
6	Dental Care			visits										6	
7	Work Related Program			hrs										7	
8	Habilitation			hrs										8	
9	Pharmacy	39(2)		# of prescripts					38,214			38,214		9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs										10	
11	Academic Education			hrs										11	
12	Exceptional Care Program													12	
13	Other (specify): Oxygen	39(2)							8,738			8,738		13	
14	TOTAL				\$	75,134		\$	\$	46,952	3,342	\$	122,086	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed
on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 711,235	\$ 711,235	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	1,454,155	1,454,155	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,057	3,057	6
7	Other Prepaid Expenses	9,788	9,788	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Tuition Grant</u>	2,670	2,670	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,180,905	\$ 2,180,905	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,984	200,000	13
14	Buildings, at Historical Cost	1,359,539	1,413,506	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	495,507	479,699	16
17	Accumulated Depreciation (book methods)	(524,746)	(452,070)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,539,284	\$ 1,641,135	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,720,189	\$ 3,822,040	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 356,453	\$ 356,453	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,370	117,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,443	18,443	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,251	65,251	32
33	Accrued Interest Payable	9,583	9,583	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	4,262	4,262	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 571,362	\$ 571,362	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,798,749	2,798,749	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,798,749	\$ 2,798,749	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,370,111	\$ 3,370,111	46
47	TOTAL EQUITY (page 18, line 24)	\$ 350,078	\$ 451,929	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,720,189	\$ 3,822,040	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,019	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,019	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	319,059	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 319,059	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 350,078	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,690,197	1
2	Discounts and Allowances for all Levels	(5,406)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,684,791	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	243,428	6
7	Oxygen	2,760	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 246,188	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,990	15
16	Rental of Facility Space		16
17	Sale of Drugs	104,987	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray	38,889	20
21	Other Medical Services	2,450	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 149,316	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	18	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	1,142	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,142	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,081,455	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	629,663	31
32	Health Care	1,211,829	32
33	General Administration	419,897	33
B. Capital Expense			
34	Ownership	354,327	34
C. Ancillary Expense			
35	Special Cost Centers	93,025	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,762,396	40
41	Income before Income Taxes (line 30 minus line 40)**	319,059	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 319,059	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Havana Health Care Center**

0046086

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 45,938	\$ 22.09	1
2	Assistant Director of Nursing	2,080	2,080	37,856	18.20	2
3	Registered Nurses	6,284	6,532	119,543	18.30	3
4	Licensed Practical Nurses	14,005	14,596	228,698	15.67	4
5	CNAs & Orderlies	48,298	49,704	499,417	10.05	5
6	CNA Trainees					6
7	Licensed Therapist	3,342	3,382	75,134	22.22	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	23,502	11.30	9
10	Activity Assistants	2,370	2,414	17,399	7.21	10
11	Social Service Worker	2,080	2,080	22,512	10.82	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,413	11.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,472	14,837	111,849	7.54	15
16	Dishwashers					16
17	Maintenance Worker	2,640	2,640	40,361	15.29	17
18	Housekeepers	10,416	10,806	83,406	7.72	18
19	Laundry	4,174	4,377	40,332	9.21	19
20	Administrator	2,080	2,080	61,538	29.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,702	2,702	27,907	10.33	24
25	Vocational Instructor					25
26	Academic Instructor					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care (Care plans)	2,096	2,096	33,856	16.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,279	126,566	\$ 1,493,661 *	\$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	12 visits	14,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	4 visits	200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,800		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Susan Showalter	Administrator	100	\$ 61,538	Workers' Compensation Insurance		\$ 56,709	IDPH License Fee		\$ 1,990		
				Unemployment Compensation Insurance		28,431	Advertising: Employee Recruitment		288		
				FICA Taxes		110,360	Health Care Worker Background Check (Indicate # of checks performed 4)		50		
				Employee Health Insurance		39,765	Miscellaneous licenses		502		
				Employee Meals		81	Miscellaneous permits		185		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous dues & subscriptions		1,352		
				Life insurance		889					
				Pension contribution		4,449					
				Employee morale		5,034					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Home office allocation		3,112		
B. Administrative - Other											
Description			Amount				Less: Public Relations Expense		(1,077)		
N/A			\$				Non-allowable advertising		()		
							Yellow page advertising		()		
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,402		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 245,718					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**d			
C. Professional Services				Description		Line #	Amount		Description		Amount
Vendor/Payee	Type		Amount	N/A			\$		Out-of-State Travel		\$
Altschuler, Melvoin and Glasser, LLP	Accounting		5,600								
McQuellon Consulting, Inc.	Operations consulting		2,185						In-State Travel		
IVANS	Computer Consulting		333								
Medifax-EDI, Inc.	Computer Consulting		138								
Advanced Answers On Demand, Inc	Computer Consulting		708						Seminar Expense		
ADP	Computer Consulting		1,025						Home office allocation		677
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL			\$		TOTAL		\$ 677

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Havana Health Care Center
Provider #: 0046086
01/01/2005 to 12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,989
------------------------------------------------	-------

Allocated from Management Company - Legal	129
-------------------------------------------	-----

Allocated from Management Company - Other	6,706
-------------------------------------------	-------

Total (agree to Schedule V, line 19, column 8)	<u>16,824</u>
------------------------------------------------	---------------

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2002	7 FY2003	8 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	14 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7						N/A							
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center# 0046086Report Period Beginning: 01/01/2005 Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these function
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 81 Has any meal income been offset against related costs? No Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT

11:34 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	72,593	equal to	72,593	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	193,805	equal to	193,805	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	67,200	equal to	67,200	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	115,287	equal to	115,287	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	546	equal to	546	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,487	equal to	6,487	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	75,134	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	75,134	equal to	75,134	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	46,952	equal to	46,952	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	629,663	equal to	629,663	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,211,829	equal to	1,211,829	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	419,897	equal to	419,897	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	354,327	equal to	354,327	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	93,025	equal to	93,025	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	53,655	equal to	53,655	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	931,452	equal to	965,308	-33,856	FAILED	OK MDS Coord	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	75,134	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	40,901	equal to	40,901	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,512	equal to	22,512	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	136,262	equal to	136,262	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	40,361	equal to	40,361	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	83,406	equal to	83,406	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	40,332	equal to	40,332	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	61,538	equal to	61,538	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	27,907	equal to	27,907	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,493,661	equal to	1,493,661	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,600	< or = to	14,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	200	< or = to	200	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	5,312	-5,312	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	61,538	equal to	61,538	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,989	equal to	9,989	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	245,718	equal to	245,718	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,402	equal to	6,402	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	677	equal to	677	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	53,655	equal to	53,655	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	81	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	81	equal to	81	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,080	equal to	2,080	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	101,574	equal to	101,574	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	2,798,749	equal to	2,798,749	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	65,251	equal to	65,251	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,413,506	equal to	1,413,506	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	479,699	equal to	479,699	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	452,070	equal to	452,070	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	350,078	equal to	350,078	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	319,059	equal to	319,059	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,720,189	equal to	3,720,189	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Havana Health Care Center
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column ===== 3
Census (Pulls from Page 2) 27,635

Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003)	
			State	HSA
1	Dietary	5.75	6.01	5.50
2	Food Purchase	5.89	4.31	4.27
3	Housekeeping	3.42	3.70	2.91
4	Laundry	1.75	1.85	1.79
5	Heat & Other Utilities	3.09	2.95	2.94
6	Maintenance	3.19	3.01	2.99
8	Total General Services	23.12	22.58	21.14
10	Nursing & Medical Records	38.29	41.83	38.37
10A	Therapy	2.72	2.10	3.34
11	Activities	1.70	1.91	1.61
12	Social Services	0.81	1.42	1.05
16	Total Health Care & Programs	44.08	49.48	46.39
17	Administration	3.08	3.36	3.15
19	Professional Services	0.61	0.99	0.83
21	Clerical & Gen. Office Expense	2.75	4.79	3.98
22	Employee Benefits & PR Taxes	8.89	10.09	8.88
24	Travel & Seminar	0.02	0.08	0.10
26	Insurance-Property, Liability & Malpractice	1.54	2.58	2.35
28	Total General Administrative	17.88	24.94	23.02
29	Total Operating Expenses	85.08	98.06	92.47
30	Depreciation	4.17	3.70	3.29
32	Interest	7.01	2.54	2.09
33	Real Estate Taxes	2.43	1.38	0.82
37	Total Ownership	13.87	11.11	8.00
	Total Operating and Ownership Cost	98.95	109.17	100.47

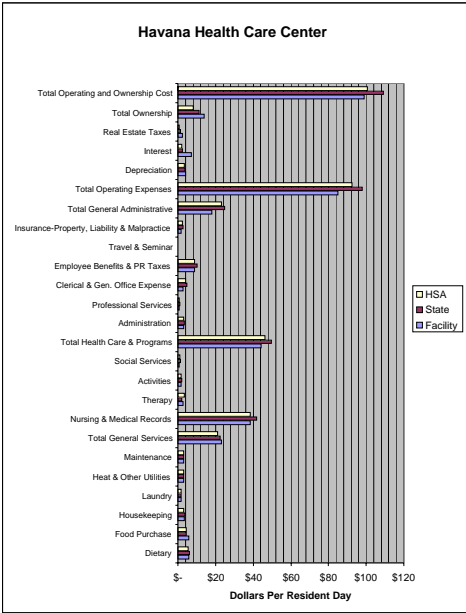
Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Cost Report Line	Description	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.26	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58
	TOTAL OPERATING & OWNERSHIP CC	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14

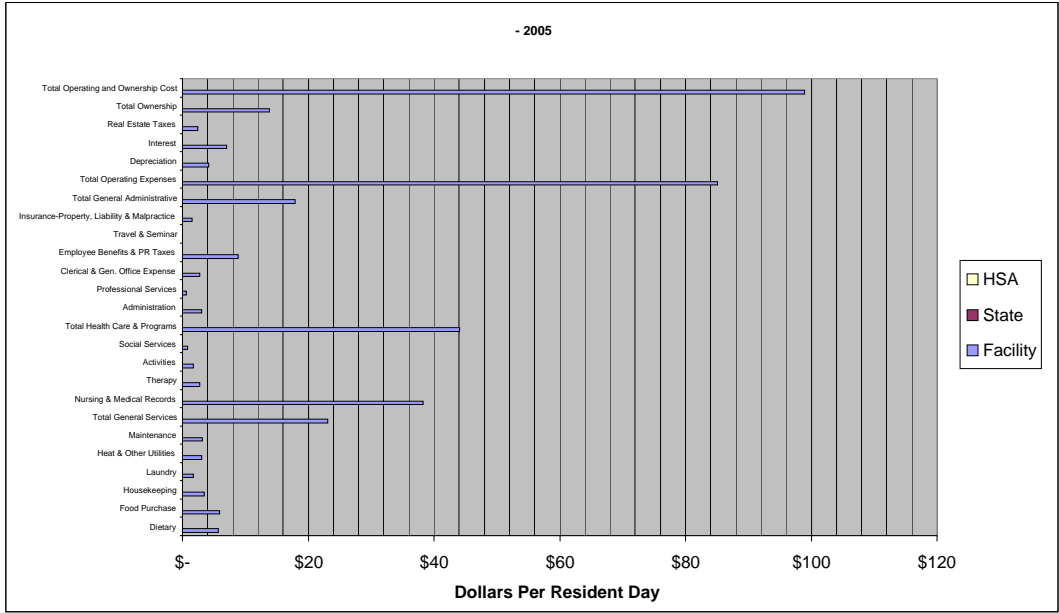


Cost Report Line	Description	2005	2004 Median		2004	2004 Median		2003	2003 Median		2002	2002 Median	
		Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA
1	Dietary	5.75	-	-	#DIV/0!	-	-	#DIV/0!	6.10	5.70	#DIV/0!	6.01	5.60
2	Food Purchase	5.89	-	-	#DIV/0!	-	-	#DIV/0!	4.31	4.11	#DIV/0!	4.27	4.09
3	Housekeeping	3.42	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.61	#DIV/0!	3.65	3.48
4	Laundry	1.75	-	-	#DIV/0!	-	-	#DIV/0!	1.85	2.13	#DIV/0!	1.90	2.23
5	Heat & Other Utilities	3.09	-	-	#DIV/0!	-	-	#DIV/0!	2.95	2.95	#DIV/0!	2.71	2.73
6	Maintenance	3.19	-	-	#DIV/0!	-	-	#DIV/0!	3.01	2.82	#DIV/0!	2.99	2.92
8	Total General Services	23.12	-	-	#DIV/0!	-	-	#DIV/0!	22.58	21.73	#DIV/0!	22.09	22.04
10	Nursing & Medical Records	38.29	-	-	#DIV/0!	-	-	#DIV/0!	41.83	42.15	#DIV/0!	40.68	41.16
10A	Therapy	2.72	-	-	#DIV/0!	-	-	#DIV/0!	2.10	2.24	#DIV/0!	1.85	2.27
11	Activities	1.70	-	-	#DIV/0!	-	-	#DIV/0!	1.91	1.54	#DIV/0!	1.88	1.60
12	Social Services	0.81	-	-	#DIV/0!	-	-	#DIV/0!	1.42	1.27	#DIV/0!	1.44	1.32
16	Total Health Care & Programs	44.08	-	-	#DIV/0!	-	-	#DIV/0!	49.48	49.49	#DIV/0!	47.55	47.76
17	Administration	3.08	-	-	#DIV/0!	-	-	#DIV/0!	3.36	3.17	#DIV/0!	3.39	3.54
19	Professional Services	0.61	-	-	#DIV/0!	-	-	#DIV/0!	0.99	0.77	#DIV/0!	0.98	0.72
21	Clerical & Gen. Office Expense	2.75	-	-	#DIV/0!	-	-	#DIV/0!	4.79	4.25	#DIV/0!	4.58	4.31
22	Employee Benefits & PR Taxes	8.89	-	-	#DIV/0!	-	-	#DIV/0!	10.09	9.08	#DIV/0!	9.63	8.44
24	Travel & Seminar	0.02	-	-	#DIV/0!	-	-	#DIV/0!	0.08	0.07	#DIV/0!	0.09	0.09
26	Insurance-Property, Liability & Malpractice	1.54	-	-	#DIV/0!	-	-	#DIV/0!	2.58	2.61	#DIV/0!	2.19	2.03
28	Total General Administrative	17.88	-	-	#DIV/0!	-	-	#DIV/0!	24.94	22.93	#DIV/0!	23.47	21.93
29	Total Operating Expenses	85.08	-	-	#DIV/0!	-	-	#DIV/0!	98.06	94.71	#DIV/0!	94.39	91.33
30	Depreciation	4.17	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.38	#DIV/0!	3.53	3.04
32	Interest	7.01	-	-	#DIV/0!	-	-	#DIV/0!	2.54	1.50	#DIV/0!	2.73	1.54
33	Real Estate Taxes	2.43	-	-	#DIV/0!	-	-	#DIV/0!	1.38	1.11	#DIV/0!	1.30	1.03
37	Total Ownership	13.87	-	-	#DIV/0!	-	-	#DIV/0!	11.11	8.39	#DIV/0!	11.44	10.00
	Total Operating and Ownership Cost	98.95	-	-	#DIV/0!	-	-	#DIV/0!	103.10	103.10	#DIV/0!	105.83	101.30

Notes:

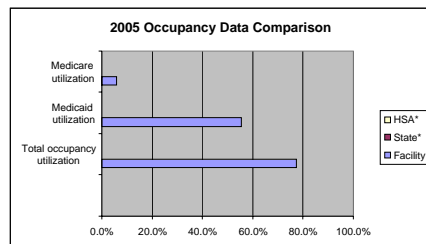
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2004, 2003 & 2002 Median Cost Per Day, for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



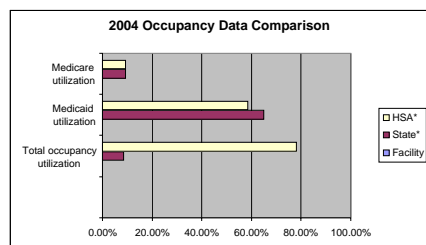
2005

	Your		
	Facility	State*	HSA*
Total occupancy utilization	77.26%	0.00%	0.00%
Medicaid utilization	55.54%	0.00%	0.00%
Medicare utilization	5.81%	0.00%	0.00%
Private pay percent utilization	15.90%	N/A	N/A
Capacity in Patient Days	35,770	N/A	N/A
Census days of service provided	27,635	N/A	N/A



2004

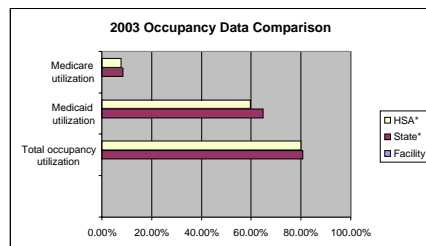
	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	8.50%	78.10%
Medicaid utilization	#DIV/0!	65.00%	58.50%
Medicare utilization	#DIV/0!	9.40%	9.30%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days	N/A	N/A	N/A
Census days of service provided	N/A	N/A	N/A



* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

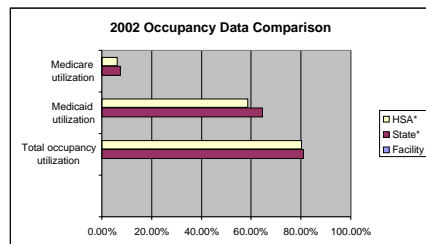
2003

	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.80%	79.90%
Medicaid utilization	#DIV/0!	64.80%	59.60%
Medicare utilization	#DIV/0!	8.50%	7.70%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days	N/A	N/A	N/A
Census days of service provided	N/A	N/A	N/A

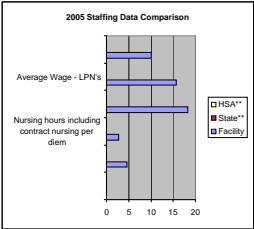


2002

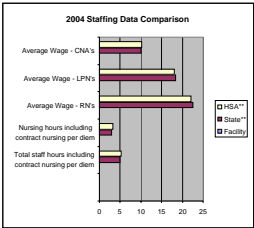
	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.90%	80.30%
Medicaid utilization	#DIV/0!	64.50%	58.50%
Medicare utilization	#DIV/0!	7.40%	6.10%
Private pay percent utilization	#DIV/0!	N/A	N/A
Capacity in Patient Days	N/A	N/A	N/A
Census days of service provided	N/A	N/A	N/A



2005			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	4.58	0.00	0.00
Nursing hours including contract nursing per diem	2.71	0.00	0.00
Average Wage - RN's	18.3	0.00	0.00
Average Wage - LPN's	15.67	0.00	0.00
Average Wage - CNA's	10.05	0.00	0.00

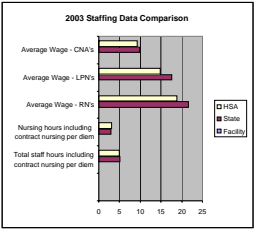


2004			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	5.00	5.30	
Nursing hours including contract nursing per diem	3.00	3.20	
Average Wage - RN's	22.54	22.05	
Average Wage - LPN's	18.40	18.02	
Average Wage - CNA's	10.02	10.13	

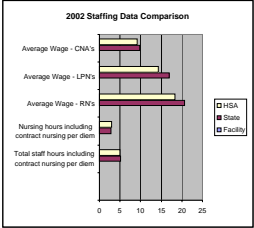


** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

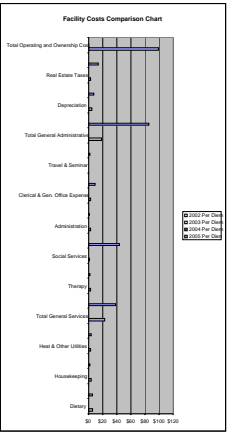
2003			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.10	5.00	
Nursing hours including contract nursing per diem	2.90	3.10	
Average Wage - RN's	21.56	18.79	
Average Wage - LPN's	17.64	14.79	
Average Wage - CNA's	9.91	9.19	



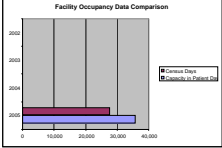
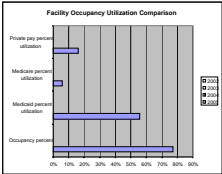
2002			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.20	5.00	
Nursing hours including contract nursing per diem	2.80	3.00	
Average Wage - RN's	20.69	18.37	
Average Wage - LPN's	16.89	14.33	
Average Wage - CNA's	9.73	9.09	



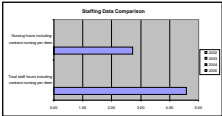
Cost Report Line	Allocation	Year		Year	
		Facility 2003	Facility 2004	Facility 2003	Facility 2004
		Per Bed	Per Bed	Per Bed	Per Bed
1	Energy	5.75	4500/03	4500/03	4500/03
2	Food Purchase	3.89	4500/03	4500/03	4500/03
3	Housekeeping	3.62	4500/03	4500/03	4500/03
4	Laundry	1.75	4500/03	4500/03	4500/03
5	Heat & Other Utilities	2.09	4500/03	4500/03	4500/03
6	Maintenance	3.19	4500/03	4500/03	4500/03
7	Total General Services	20.12	4500/03	4500/03	4500/03
8	Nursing & Medical Records	38.29	4500/03	4500/03	4500/03
9A	Therapy	2.72	4500/03	4500/03	4500/03
10	Activities	1.76	4500/03	4500/03	4500/03
12	Social Services	0.61	4500/03	4500/03	4500/03
16	Total Health Care & Programs	46.08	4500/03	4500/03	4500/03
17	Administration	3.68	4500/03	4500/03	4500/03
19	Professional Services	0.41	4500/03	4500/03	4500/03
21	Child & Gen. Office Expense	2.75	4500/03	4500/03	4500/03
22	Employee Benefits & FR Taxes	8.85	4500/03	4500/03	4500/03
24	Travel & Lodging	0.02	4500/03	4500/03	4500/03
26	Insurance-Property, Liability & Malpractice	1.54	4500/03	4500/03	4500/03
36	Total General Administration	17.66	4500/03	4500/03	4500/03
39	Total Operating Expenses	67.68	4500/03	4500/03	4500/03
39	Depreciation	6.17	4500/03	4500/03	4500/03
42	Interest	7.66	4500/03	4500/03	4500/03
51	Real Estate Taxes	2.43	4500/03	4500/03	4500/03
57	Total Ownership	15.87	4500/03	4500/03	4500/03
Total Operating and Ownership Cost		96.95	4500/03	4500/03	4500/03



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Occupancy percent	77.28%	4500/03	4500/03	4500/03
Medicaid percent utilization	55.54%	4500/03	4500/03	4500/03
Medicare percent utilization	5.81%	4500/03	4500/03	4500/03
Private pay percent utilization	92.85%	4500/03	4500/03	4500/03
Capacity in Patient Days	35,770	0	0	0
Census Days	27,608	0	0	0



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Total staff hours including contract nursing per day	4.38	0.00	0.00	0.00
Nursing hours including contract nursing per day	2.71	0.00	0.00	0.00
Average Wage - BSN	18.36	0.00	0.00	0.00
Average Wage - LPN	15.47	0.00	0.00	0.00
Average Wage - CNA	10.00	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	136,262	19,195	0	155,457	0	155,457	3,324	158,781
2. Food Purchase	0	162,776	0	162,776	0	162,776	105	162,881
3. Housekeeping	83,406	11,020	0	94,426	0	94,426	75	94,501
4. Laundry	40,332	8,048	0	48,380	0	48,380	6	48,386
5. Heat and Other Utilities	0	0	84,758	84,758	0	84,758	506	85,264
6. Maintenance	40,361	36,069	7,436	83,866	0	83,866	4,360	88,226
7. Other (specify)*	0	0	0	0	0	0	949	949
8. Total General Services	300,361	237,108	92,194	629,663	0	629,663	9,325	638,988
9. Medical Director	0	0	14,600	14,600	0	14,600	0	14,600
10. Nursing & Medical Records	965,308	87,157	200	1,052,665	0	1,052,665	5,497	1,058,162
10a. Therapy	75,134	0	0	75,134	0	75,134	4	75,138
11. Activities	40,901	705	5,312	46,918	0	46,918	0	46,918
12. Social Services	22,512	0	0	22,512	0	22,512	0	22,512
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	762	762
16. Total Health Care & Programs	1,103,855	87,862	20,112	1,211,829	0	1,211,829	6,263	1,218,092
17. Administrative	61,538	0	0	61,538	0	61,538	23,543	85,081
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,989	9,989	0	9,989	6,835	16,824
20. Fees, Subscriptions & Promotion	0	0	4,367	4,367	0	4,367	2,035	6,402
21. Clerical & General Office	27,907	6,296	11,528	45,731	0	45,731	30,377	76,108
22. Employee Benefits & Payroll	0	0	245,718	245,718	0	245,718	0	245,718
23. Inservice Training & Education	0	0	7,624	7,624	0	7,624	494	8,118
24. Travel and Seminar	0	0	0	0	0	0	677	677
25. Other Admin. Staff Trans	0	0	3,197	3,197	0	3,197	2,462	5,659
26. Insurance-Prop.Liab.Malpractice	0	0	41,733	41,733	0	41,733	899	42,632
27. Other (specify)*	0	0	0	0	0	0	6,758	6,758
28. Total General Adminis	89,445	6,296	324,156	419,897	0	419,897	74,080	493,977
29. Total General Administrative	1,493,661	331,266	436,462	2,261,389	0	2,261,389	89,668	2,351,057
30. Depreciation	0	0	92,773	92,773	0	92,773	22,514	115,287
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	188,001	188,001	0	188,001	5,804	193,805
33. Real Estate	0	0	67,200	67,200	0	67,200	0	67,200
34. Rent - Facility & Grounds	0	0	0	0	0	0	546	546
35. Rent - Equipment & Vehicles	0	0	6,353	6,353	0	6,353	134	6,487
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	354,327	354,327	0	354,327	28,998	383,325
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	46,952	0	46,952	0	46,952	0	46,952
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	53,655	53,655	0	53,655	0	53,655
43. Other (specify):*	0	0	46,073	46,073	0	46,073	-46,073	0
44. Total Special Cost Ce	0	46,952	99,728	146,680	0	146,680	-46,073	100,607
45. Grand Total	1,493,661	378,218	890,517	2,762,396	0	2,762,396	72,593	2,834,989

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	711,235	711,235
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	1,454,155	1,454,155
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	3,057	3,057
7. Other Prepaid Expenses	9,788	9,788
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	2,670	2,670
10. Total current assets	2,180,905	2,180,905
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	208,984	200,000
14. Buildings, at Historical Cost	1,359,539	1,413,506
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	495,507	479,699
17. Accumulated Depreciation (book methods)	-524,746	-452,070
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,539,284	1,641,135
25. Total Assets	3,720,189	3,822,040
CURRENT LIABILITIES		
26. Accounts Payable	356,453	356,453
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	117,370	117,370
31. Accrued Taxes Payable	18,443	18,443
32. Accrued Real Estate Taxes	65,251	65,251
33. Accrued Interest Payable	9,583	9,583
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	4,262	4,262
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	571,362	571,362
LONG TERM LIABILITES		
39. Long-Term Notes Payable	2,798,749	2,798,749
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,798,749	2,798,749
46. Total Liabilities	3,370,111	3,370,111
47. Total Equity	350,078	451,929
48. Total Liabilities and Equity	3,720,189	3,822,040

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,690,197
2. Discounts and Allowances for all Levels	-5,406
Subtotal - Inpatient Care	2,684,791
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	243,428
7. Oxygen	2,760
Subtotal - Ancillary Revenue	246,188
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	2,990
16. Rental of Facility Space	0
17. Sale of Drugs	104,987
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	38,889
21. Other Medical Services	2,450
22. Laundry	0
Subtotal - Other Operating Revenue	149,316
24. Contributions	0
25. Interest and Other Investments Income	18
Subtotal - Non-Operating Revenue	18
27. Other Revenue (specify):	1,142
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,142
30. Total Revenue	3,081,455
31. General Services	629,663
32. Health Care	1,211,829
33. General Administration	419,897
34. Ownership	354,327
35. Special Cost Centers	93,025
35. Provider Participation Fee	53,655
37. Other	0
40. Total Expenses	2,762,396
41. Income Before Income Taxes	319,059
42. Income Taxes	0
43. Net Income or Loss for the Year	319,059

Page

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

Cost Report	Description
Line	
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

Average Wage Data Table

Total staff hours including contract nurses per diem
Nursing hours including contract nurses per diem
RN
LPN
CNA
DON
ADON

2003 - Staffing and Occupancy Data

Average Occupancy
Medicaid Utilization
Medicare Utilization

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11	

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11	

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11	

Cost Report	Description	2005 Costs	2005 Census
Line			
1	Dietary		
2	Food Purchase		
3	Housekeeping		
4	Laundry		
5	Heat & Other Utilities		
6	Maintenance		
8	TOTAL GENERAL SERVICES		
10	Nursing & Medical Records		
10A	Therapy		
11	Activities		
12	Social Services		
16	TOTAL HEALTH CARE & PROGRAMS		
17	Administration		
19	Professional Services		
21	Clerical & Gen. Office Expense		
22	Employee Benefits & PR Taxes		
24	Travel & Seminar		
26	Insurance-Property, liability & Malpractice		
28	TOTAL GENERAL ADMINISTRATIVE		
29	TOTAL OPERATING EXPENSES		
30	Depreciation		
32	Interest		
33	Real Estate Taxes		
37	TOTAL OWNERSHIP		
	TOTAL OPERATING & OWNERSHIP COST		27,635

LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004)

Havana
Health
Care
Center
2004
CostsHavana
Health
Care
Center
2004
Census

Cost	
<u>Line</u>	<u>Description</u>
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
11	Therapy
12	Activities
13	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
32	Depreciation
33	Interest
37	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

2003 - Staffing and Occupancy Data

	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.30	3.30	3.20	3.10	2.80	2.80	2.80	3.10	3.20	3.10
RN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	22.05	20.42
LPN	18.84	18.02	17.23	15.4	17.23	13.87	21.06	21.06	21.06	19.99	18.02	17.13
CNA	10.02	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	10.53	10.13	9.84
DON	28.97	27.38	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	27.38	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.95	23.77

2003 - Staffing and Occupancy Data												
	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	8.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.10%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	10.30%	7.70%	8.90%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Havana
Health Care
Center

Havana
Health
Care
Center

2003
Census

Cost Report Line	Description	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
		1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	73.16	166.14

Cost Report Line	Description	10th %	90th %
1	Dietary	4.13	9.81
2	Food Purchase	3.36	6.04
3	Housekeeping	2.48	5.80
4	Laundry	0.91	3.14
5	Heat & Other Utilities	2.05	4.25
6	Maintenance	1.92	5.12
8	TOTAL GENERAL SERVICES	17.57	31.51
10	Nursing & Medical Records	27.25	64.47
10A	Therapy	-	10.55
11	Activities	1.06	3.45
12	Social Services	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	32.10	77.23
17	Administration	1.71	7.21
19	Professional Services	0.07	3.44
21	Clerical & Gen. Office Expense	2.49	10.78
22	Employee Benefits & PR Taxes	6.33	19.34
24	Travel & Seminar	-	0.43
26	Insurance-Property, liability & Malpractice	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	16.95	39.14
29	TOTAL OPERATING EXPENSES	69.40	142.56
30	Depreciation	1.01	8.43
32	Interest	-	11.53
33	Real Estate Taxes	-	4.85
37	TOTAL OWNERSHIP	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	73.16	166.14

Average Wage Data Table

	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
		1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.20	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14	20.33
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65	16.45
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11	9.76
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67	24.62
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.67	22.50

2003 - Staffing and Occupancy Data

	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
		1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%	77.30%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%	59.30%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%	8.00%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2002 Cost Reports
2002 (Run June 1, 2004)

UN-INFLATED

Cost Report	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
Line	Description	1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	3.89	3.84	3.48	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	1.89	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	1.95	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	26.11	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	1.13	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	52.75	50.19	47.76	31.31	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	1.65	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.19	1.00	0.07	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	4.19	4.07	4.31	2.36	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	6.22	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	-	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	0.83	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	23.10	23.64	21.93	16.13	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	97.86	99.26	91.33	67.15	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	0.73	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	-	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	-	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	11.40	9.19	10.00	3.55	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	109.26	108.45	101.30	70.70	163.08

Cost Report	2002 Costs	2002 Census
Line	Description	
1	Dietary	
2	Food Purchase	
3	Housekeeping	
4	Laundry	
5	Heat & Other Utilities	
6	Maintenance	
8	TOTAL GENERAL SERVICES	
10	Nursing & Medical Records	
10A	Therapy	
11	Activities	
12	Social Services	
16	TOTAL HEALTH CARE & PROGRAMS	
17	Administration	
19	Professional Services	
21	Clerical & Gen. Office Expense	
22	Employee Benefits & PR Taxes	
24	Travel & Seminar	
26	Insurance-Property, liability & Malpractice	
28	TOTAL GENERAL ADMINISTRATIVE	
29	TOTAL OPERATING EXPENSES	
30	Depreciation	
32	Interest	
33	Real Estate Taxes	
37	TOTAL OWNERSHIP	
	TOTAL OPERATING & OWNERSHIP COST	

2002 - Average Wage Data Table

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.37	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	10.05
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.20%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	8.20%	6.80%	7.00%